Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN205AGC	A. BUILDING _____ B. WING _____	C 04/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY GROUP CARE	2690 MARGARET DR RENO, NV 89506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility 4/9/09 to 4/22/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, Category II residents. Complaint #NV00021531 was substantiated. See Tag Y0515	Y 000		
Y 515 SS=G	449.259(1)(a) Supervision of Residents NAC 449.259 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary. This Regulation is not met as evidenced by: Based on observation, interview, record review and police report review from 4/9/09 to 4/22/09, the administrator failed to provide adequate protective supervision for 1 of 6 residents (Resident #1).	Y 515		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 515	Continued From page 1 Findings include: Resident #1 was admitted to the facility on 5/31/07 with diagnoses of schizophrenia and hypothyroidism. The resident's physician began the resident on Depakote in March because she was talking to herself. The bureau received notification on 4/8/09 that Resident #1 walked away from the facility on 4/3/09 and was later found at a women's shelter. The social worker for the resident reported on 4/9/09 that she was informed of the incident by Elder Protective Services (EPS) on 4/8/09 and the administrator failed to call on the day of the incident. An investigation at the facility was initiated on 4/9/09 with interviews of the administrator, Resident #1 and other residents in the facility. The EPS report was received 4/10/09. The police report was received on 4/21/09 and additional interviews with the administrator and residents were conducted on 4/22/09. The following is a brief summary of the incident: The administrator reported Resident #1 was having a "bad day" on 4/3/09. She stated the resident claimed the clothes in her closet were not hers when the administrator was helping her get dressed; the resident was "pacing" from the living room to the front door and back; and she was talking to herself more than usual. The administrator saw her opening the door to look outside and told her it was too windy to go for a walk. The administrator reported she occasionally took Resident #1 on walks in the neighborhood but the resident was not allowed to go on walks by herself.	Y 515		

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Y 515	Continued From page 2 The administrator reported that in the afternoon on 4/3/09, she was on the back patio. Between 2:00-2:30 PM she came into the house and noticed Resident #1 was not in the living room or anywhere in the house. She stated she got in her car and drove around the neighborhood looking for the resident for 20 minutes. (The house is located in a country neighborhood surrounded by horse property.) Another resident had a 3:00 PM doctor's appointment and at 2:45 PM she returned to the facility so she could drive the resident to the appointment. The administrator stopped looking for Resident #1 and left the facility without ensuring the resident was safely back in the facility The administrator related that she realized Resident #1 had gotten lost but she knew the "resident was not confused" and would hopefully find her way home. The administrator admitted she did not call anyone about Resident #1 being missing from the house. She admitted she did not take the time to call the resident's social worker and stated she planned to her call if the resident was still gone when she came back from doctor's office. The Reno police have an officer stationed at the Record Street women's shelter. In a report, a police officer indicated a woman was driving in Golden Valley and saw Resident #1 standing in the middle of a street. The woman stopped and talked to the resident, thought she was confused and gave the resident a ride to the women's shelter. The officer interviewed the resident, made phone calls and was able to determine the resident was from the facility. Workers at the shelter reported they called the administrator to let her know Resident #1 was in their shelter. The workers reported the administrator said the resident had been gone for a couple hours, which	Y 515		

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Y 515	Continued From page 3 the administrator denied in an interview. The administrator reported she received a phone call from the shelter while on the way to the resident's doctor's office. She stated she took the other resident to the doctor's office and was there for around 30 minutes talking the resident's doctor and guardian. She related that she received a second call from the shelter, this time from a police officer, and she went down to pick up the resident. Workers at the shelter indicated in their statements and during interview that Resident #1 was at the shelter for more than an hour after the first phone call to the administrator. They reported they asked a second police officer to call the administrator again because she had not shown up and it was getting late. The workers were also worried about the resident because her hair was oily and matted, and she was wearing a thin jacket in 40 degree weather. The police officer indicated in his report that he questioned the administrator about letting the resident go on walks by herself, and that the administrator reported her residents could go for walks but got lost if they turned the corner from the street in front of the facility. The shelter workers indicated the resident seemed to be mad at the administrator and initially resisted the administrator's request to leave with her. Resident #1 reported she had taken some walks with the administrator but did not go for walks on her own. When asked why she left for a walk without the administrator, she stated "I just needed to get out of there" and decided to walk to the "center" to see what they were doing there. She related that she walked for a long time then got a ride from a nice woman who took her to the	Y 515		

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Y 515	Continued From page 4 center. The resident reported the center was not what she expected as the women there were younger than she was and they were not doing anything different than what she did at the facility - just sitting around watching TV or listening to music - so she was disappointed. On 4/3/09, the administrator noticed a change in Resident #1's behavior and did not prevent the resident from leaving the facility on her own, and then failed to ensure the resident safely returned to the facility before taking another resident to an appointment. Severity: 3 Scope: 1	Y 515		